Pontchartrain Pediatrics

Authorization for Release of Medical Record Information

PLEASE USE BLACK INK

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Home Telephone No.:_____ **Work Telephone:** _____

I hereby authorize:

Doctor's Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

To disclose information for my child's medical record to:

Pontchartrain Pediatrics, LLC

4405 Hwy 190, East Service Rd.

Covington, LA 70433

Fax: 985-893-0093

The information is needed for the following reason:

_____ Change of Practice **_____ Shot Records** **_____ Lab Results**

_____ X-Rays **_____ Other**

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) period from the date it is signed.

By:_____ **Current date:** _____
Parent or legal guardian (if minor children)

Witness: _____ **Date:** _____